Health Care Authority
Grievance System and Non-Participating Provider Reporting Instructions
(Effective January 1, 2015)

Non-Participating Provider Reporting:

The Managed Care Organization (MCO) shall provide annual reports to the HCA for the preceding state fiscal year July 1st through June 30th. The reports shall indicate the proportion of services provided by the MCO's participating providers and non-participating providers, by county, and including hospital-based physician services in a format provided by HCA. The MCO shall submit the report to the HCA no later than November 1st of each year, or as required by the HCA.

1. **Column B:** The total cost of overall services (claims paid), per county, to all providers for services provided to enrollees under the Contract for July 1 – June 30 of the preceding fiscal year.
2. **Column C:** The percent of overall cost of services (claims paid), per county, paid to non-participating providers, including hospital-based physician services, provided to enrollees under the Contract for July 1 – June 30 of the preceding fiscal year.

   Data must be provided using the HCA Excel workbook template entitled GAAandNPPformat.xls under the tab identified as MCONPPrpt201X-201X.

Grievance System Reporting:

Calendar Quarter: Quarter in which the MCO received grievances, actions, appeals, IROs, or State hearings.

Data submission:	4th Quarter = October - December	**Due: January 30**
	1st Quarter = January - March	**Due: April 30**
	2nd Quarter = April - June	**Due: July 31**
	3rd Quarter = July - September	**Due: October 30**

- Data must be in the Excel format described below and submitted electronically through the HCA Secure File Transfer (SFT) - also known as Tumbleweed/Valicert website. The submitter must send an upload notification to the general managed care mailbox at hcamcprograms@hca.wa.gov.
- Data must be provided using the HCA Excel workbook template entitled GAAandNPPformat.xls under the tab identified as MCO-GAArptQX-XX. The submitted Excel file must be labeled with the MCO name, reporting year, and quarter (Example: MCO-GAArptQ2-15).
- Within two weeks after the quarterly data submission, the MCO must submit a comprehensive written report including evidence of the examination of data and a written analysis of the MCO grievances, actions, and appeals for the submitted quarter. The information provided should include:
  - Identified trends;
  - Recommendations for improvement, based on the grievance, action, and appeal analysis (i.e., description of findings, quarterly-to-quarterly comparisons, results of any action(s) taken in prior submissions, etc.);

- Actions to address common causes.; and
- HCA will use data submitted to validate MCO reports.

DEFINITIONS

Action/Denial: An Action/Denial is:

(1) The denial or limited authorization of a requested service, including the type or level of service;
(2) The reduction, suspension, or termination of a previously authorized service;
(3) The denial, in whole or in part, of payment for a service;
(4) The failure to provide services in a timely manner, as defined by the State;
(5) The failure of an MCO to act within the timeframes provided in Sec. 438.408(b); or
(6) For a resident of a rural area with only one MCO, the denial of a Medicaid enrollee's request to exercise his or her right, under Sec. 438.52(b)(2)(ii), to obtain services outside the network.

Appeal: A request by a covered person or provider for reconsideration of a decision such as, but not limited to, a denial, an action other than a denial, a benefit payment, an administrative action/denial, or quality of care or service issue. An Appeal is a request for the MCO to review an action/denial.

CSHCN: Children with Special Health Care Needs mean children under 19 years of age whom are any one of the following:
(1) Eligible for SSI under Title XVI;
(2) Eligible under section 1902(e)(3) of the Act;
(3) In foster care or other out-of-home placement;
(4) Receiving foster care or adoption assistance; and/or
(5) Receiving services through a family-centered, community-based, coordinated care system that receives grant funds under section 501(a)(1)(D) of Title V.

ISHCS: Individual with Special Health Care Needs means an enrollee who meets the Contract diagnostic and risk score criteria for Health Home Services; or is a Child with Special Health Care Needs; or has a chronic or disabling condition that meets all of the following conditions:
(1) Has a biologic, psychologic, or cognitive basis;
(2) Has a chronic disease or disabling healthcare condition that is likely to continue for more than one year; and
(3) Produce one or more of the following conditions stemming from a disease:
(4) Significant limitation in areas of physical, cognitive, or emotional function; or
(5) Dependency on medical or assistive devices to minimize limitation of function or activities.

Expedited: An appeal must be expedited if the enrollee's provider or the MCO reasonably determines that the appeal process timelines could seriously jeopardize the enrollee's life, health, or ability to regain maximum function. The decision regarding an expedited appeal must be made within three calendar days after the appeal is received.

Grievance/Complaint: An expression of dissatisfaction about any matter other than an action/denial. The term is also used to refer to the overall system that includes grievances/complaints and appeals handled at the MCO level and access to the State Hearing process.

Possible subjects for grievances/complaints include, but are not limited to:

- The quality of care or service;
- Access to care;
- Enrollee liability for payment;
- Aspects of interpersonal relationships such as rudeness of a provider or employee; or
- Failure to respect the enrollee's rights.

The MCO must register all grievances/complaints and must count each separately whether the grievance/complaint is remedied by the MCO immediately or through its grievance/complaint and quality of care and service procedures, regardless of whether it is substantiated. If an enrollee has a number of different grievances/complaints, the MCO must register each one separately.

The MCO must register and count any grievance/complaint sent by a state agency, HCA or the Office of the Insurance Commissioner (OIC), whether the grievance/complaint is remedied by the plan or through its grievance/complaint and quality of care and service procedures, regardless of whether it is substantiated.

*Inquiry: A written or verbal question or request for information posed to the MCO such as benefit questions, contract issues, or organization rules. Inquiries do not reflect enrollee grievance/complaint or disagreements with MCO determinations. Inquiries **are not** to be counted as a grievance/complaint.*

Examples:

1) An ID card request or a request to change primary care providers (PCP) is considered an inquiry unless the enrollee is filing a grievance/complaint because previous requests were not answered satisfactorily.
2) The clarification of the receipt of an Explanation of Benefits (EOB) when the member believes he or she has received a bill. This is a member education opportunity, not a grievance/complaint.

Provider/Practitioner: Practitioner involved in the grievance/complaint, action/denial, or appeal. Practitioners are usually required to be licensed as defined by law. For HCA reporting purposes, a provider is a health care professional, such as a physician or any providers acting within the scope of his or her practice (as defined by 42 CFR 438.2). Examples of Providers/Practitioners include, but are not limited to physicians, cardiologists, podiatrists, optometrists, physician assistants, physical therapists, clinical nurse specialists, registered or practical nurses, and pharmacists.

Resolution: The final determination by the MCO to resolve the grievance/complaint, action/denial, or appeal.

MCO GAA FORMAT REPORTING GUIDELINES

To use GAA information for a comparative data analysis, HCA contractually requires MCOs to use the grievance/complaint, action/denial, appeal, IRO, and state hearing categories as identified in the within the HCA Excel file "GAA Data requirements and Format XX-XX-2015."

Column A: Indicate reporting MCO with common abbreviation.

Column B: – Identify the MCO's delegated entity that receives and takes action on grievances/complaints, actions/denials, or appeals. The MCO is responsible to integrate the delegated entity's data into its data. There should be no separate data submission for the delegated entities. HCA advises the MCO downstream the report instructions and format to their delegated entities to facilitate administrative simplification and roll up of combined MCO/delegate data.

Column C: Indicate the reporting period the initial grievance/complaint, action/denial, or appeal is received. Reporting format: 1, 2, 3, or 4.

Column D: Specify the program for the data submitted using the program acronyms as follows:

HO – Identifies Healthy Options/Apple Health Family Coverage enrollees.

HOBD – Identifies Healthy Options/Apple Health Blind Disabled enrollees.

HOFC – Identifies Healthy Options/Apple Health Foster Care enrollees.

HH – Identifies Health Home enrollees when applicable to the reporting MCO.

SCHIP– Identifies Children's Health Insurance Program/Apple Health with Premium enrollees.

WMIP – Identifies Washington Medicaid Integration Partnership enrollees **when applicable** to the reporting MCO.

AHAC – Identifies Apple Health Adult Coverage enrollees related to the Medicaid Expansion population (Alternative Benefit Plan).

Column E: Identify all Individuals (ISHCN) and Children with Special Health Care Needs (CSHCN) with an "X."

Column F: Populate column with the enrollee's HCA ProviderOne ID number.

Column G: Enter enrollee's last name.

Column H: Enter enrollee's first name.

Column I: Enter enrollee's middle initial.

Column J: Enter enrollee's birth date in MM/DD/YYYY format (example: 12/01/1985).

Column K: Identify the servicing provider/practitioner's last name, either as the source of an enrollee's grievance/complaint; or the provider of service the MCO took action upon, denied, or is addressing the enrollee's service. **This field must be populated when applicable or left blank.**

Column L: Identify the provider/practitioner's first name. **This field must be populated when applicable or left blank.**

Column M: Identify the provider/practitioner's middle initial. **This field must be populated when applicable or left blank.**

Column N: Identify type or specialty of provider/practitioner. Should be no more than thirty (30) characters. Examples: Family Practitioner, Chiropractor, Acupuncturist, Surgeon, General Surgeon, Orthopedist, Urologist, Internal Medicine, Certified Nurse Practitioner, Dermatologist, etc. **This field must be populated when applicable or left blank.**

Column O: Identify the individual provider/practitioner's National Provider Identifier (NPI). Example format: 1112345678. **This field must be populated when applicable or left blank.**

Column P: Identify the facility or clinic the provider/practitioner is associated or contracted with and which is associated with the grievance/complaint, action/denial, or appeal. **This field must be populated when applicable or left blank.**

Column Q: Specify the category and the level for the data submitted as follows:

1= Grievance/complaint
2= Action/denial
3= Appeal
4= Independent Review Organization (IRO)
5= State hearing

Column R: Identify the urgency of the grievance/complaint or appeal. Reporting format: "X" if expedited, leave blank if not expedited.

Column S: Describe the "what" or the catalyst for the grievance/complaint, action/denial, appeal, IRO, or State hearing. (NOTE: "Other" category should be used sparingly and must include specific information related to the action or appeal.) **This key descriptive column must be populated for all records.**

Column T: Provide additional detail of the primary category in Column S. (NOTE: "Other" category should be used sparingly and must include specific information related to the grievance, action or appeal.) **This key descriptive column must be populated for all grievance/complaint, action/denial, and appeal records.**

Column U: Describe "why" the grievance/complaint, action/denial, appeal, IRO, or state hearing occurred. **This key descriptive column must be populated for all grievance/complaint, action/denial, and appeal records.**

Column V: Describe the outcome of the grievance/complaint, action/denial, appeal, IRO, or state hearing determination. This specifies all partial approvals or plan changes in a service request. **This key descriptive column must be populated for all records.**

Column W: Document the date the grievance/complaint was received, an authorization request was received (for actions including actions related to an appeal), IRO, or state hearing request was received. Reporting format: MM/DD/YYYY. **This column must be populated for all records. Note that for**

actions related to concurrent review requests, it is acceptable to use the date the pertinent information was submitted by the provider in order for the MCO to evaluate the need for continued stay.

Column X: Identify the date a grievance/complaint was responded to, a denial determination was made, or an appeal or IRO determination was made. When a grievance or appeal is identified as in process (not resolved) during a reporting period it will need to be reported on the following quarterly report with the correct reporting period in Column C and date of resolution identified. Reporting format: MM/DD/YYYY, if still in process or not applicable use 00/00/0000.

Column Y: Date written notification sent to enrollee and provider/practitioner. Reporting format: MM/DD/YYYY, if not applicable use 00/00/0000.

Column Z: Enter a unique record identifier assigned by the plan's tracking/monitoring system, for each grievance/complaint, action/denial, appeal, IRO, or state hearing.